

TEXT OF REGULATION

Title 10. Investment

Chapter 5. Insurance Commissioner

Subchapter 3. Insurers

Article 22. Essential Health Benefits

Add to Subchapter 3 of Chapter 5 of Title 10 of the California Code of Regulations new Article 22: Essential Health Benefits

Adopt: Section 2594. Definitions.

“Actuarial value” has the same meaning as defined in section 156.20 of Title 45 of the Code of Federal Regulations.

“Base-benchmark plan” means the Kaiser Foundation Health Plan, Inc. Northern California Region Small Group HMO \$30 Copayment Plan (federal health product identification number 40513CA035), as the plan was offered during the first quarter of 2012.

“Cost sharing” has the same meaning as defined in section 155.20 of Title 45 of the Code of Federal Regulations.

“Disability insurance” has the same meaning as defined in section 106 of the Insurance Code.

“Essential health benefits package” has the same meaning as defined in subsection (a) of section 1302 of PPACA (42 U.S.C. § 18022(a)).

“Excepted benefits” has the same meaning as defined in subsection (c) of section 2791 of the federal Public Health Service Act (42 U.S.C. § 300gg-91(c)).

“Exchange” means the California Health Benefit Exchange created by section 100500 of the Government Code.

“Federal Employees Dental and Vision Insurance Program plan” means the BlueCross BlueShield Association 2012 FEP BlueVision High Option plan, as specified in Appendix B of the final federal rule on Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Federal Register 12,834, 12,872 (February 25, 2013).

“Grandfathered health plan” has the same meaning as defined in section 1251 of PPACA (42 U.S.C. § 18011) and any rules, regulations, or guidance issued pursuant to that section.

“Habilitative services” has the same meaning as defined in section 10112.27 of the Insurance Code.

“Health benefits” has the same meaning as defined in section 10112.27 of the Insurance Code.

“Health insurance” has the same meaning as defined in section 106 of the Insurance Code.

“Health insurance policy form,” or “policy form,” for the purposes of this article, means a health insurance product, as defined in section 159.110 of Title 45 of the Code of Federal Regulations, which provides coverage for a uniform set of health benefits, limitations, and exclusions. A health insurance product may include one or more plans, which differ only in their level of coverage.

“Healthy Families Program plan” means the health benefits for pediatric oral care covered under the dental plan available to subscribers of the Healthy Families Program in 2011-2012.

“Level of coverage” has the same meaning as defined in section 156.20 of Title 45 of the Code of Federal Regulations.

“Pediatric services” means health benefits provided to an individual who has not attained the age of nineteen years.

“PPACA” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

“Small group health insurance policy” means a group health insurance policy issued to a small employer, as defined in section 10753 of the Insurance Code.

“Stand-alone pediatric dental plan” means a specialized health insurance policy certified by the Exchange pursuant to section 1311(d)(2)(B)(ii) of PPACA (42 U.S.C. § 18031(d)(2)(B)(ii)) and section 155.1065 of Title 45 of the Code of Federal Regulations that covers, at a minimum, the pediatric oral essential health benefit.

“Treatment limitations” means limitations on coverage of essential health benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting or benefit period, or other similar limitations on the amount, scope, or duration of covered benefits.

NOTE: Authority cited: sections 10112.27, 10112.3, 12921, and 12926, Insurance Code. Reference: sections 106, 10112.27, 10112.3, 10753, Insurance Code.

Adopt: Section 2594.1. Scope of Article.

- (a) This article shall apply to an individual or small group health insurance policy issued, amended, or renewed on or after January 1, 2014, regardless of whether the health insurance policy is sold on the Exchange or outside of the Exchange.
- (b) This article shall not apply to the following:
 - (1) An individual or small group health insurance policy that is a grandfathered health plan.
 - (2) An individual or group disability insurance policy that covers excepted benefits in accordance with subsections (b) and (c) of section 2722 of the Public Health Service Act (42 U.S.C. § 300gg-21(b), (c)), and any rules, regulations, or guidance issued pursuant to that section.
- (c) The sections of the Health and Safety Code enumerated in subdivisions (a)(2)(A)(ii) and (a)(2)(A)(iv) of section 10112.27 of the Insurance Code shall apply only to a health insurance policy subject to section 10112.27 of the Insurance Code.
- (d) Nothing in section 10112.27 of the Insurance Code or this article exempts a health insurer or health insurance policy from complying with other applicable requirements of law, including Chapter 5 of Title 10 of the California Code of Regulations.
- (e) A small group health insurance policy subject to section 10112.27 of the Insurance Code shall comply with the following sections of the Insurance Code:
 - (1) Section 10119.6.
 - (2) Section 10123.141.

NOTE: Authority cited: sections 10112.27, 12921, and 12926, Insurance Code.
Reference: sections 10112.27, 10119.6, 10123.141, Insurance Code.

Adopt: Section 2594.2. Mandatory Coverage and Standards.

- (a) An individual or small group health insurance policy shall, at a minimum, provide coverage for essential health benefits, as defined in subdivision (a) of Insurance Code section 10112.27 and section 2594.3 of this article.
- (b) An individual or small group health insurance policy shall provide coverage for the essential health benefits package, as specified in this article.
- (c) An individual or small group health insurance policy shall, at a minimum, provide coverage for essential health benefits that is substantially equal to the health benefits covered by the base-benchmark plan, the Healthy Families Program plan for pediatric oral care, and the Federal Employees Dental and Vision Insurance Program plan for pediatric vision care.
- (d) An individual or small group health insurance policy shall not impose treatment limitations on essential health benefits greater than the treatment limitations imposed by the base-benchmark plan, the Healthy Families Program plan for pediatric oral care, and the Federal Employees Dental and Vision Insurance Program plan for pediatric vision care. Treatment limitations in a health insurance policy subject to section 10112.27 of the Insurance Code shall comply with all other applicable laws and regulations, including, but not limited to, article 15.2 of this subchapter, commencing with section 2562.1.

- (e) An individual or small group health insurance policy shall not exclude an individual from coverage for essential health benefits except that an individual who does not satisfy the eligibility age for pediatric services may be excluded from the pediatric services category.
- (f) An individual or small group health insurance policy shall not substitute benefits within essential health benefit categories.
- (g) An individual or small group health insurance policy shall cover habilitative services and devices as follows:
 - (1) All habilitative services and devices covered by the base-benchmark plan shall be covered.
 - (2) Services and devices covered by the base-benchmark plan for the purpose of rehabilitation shall also be covered for the purpose of habilitation.
 - (3) The same terms and conditions applied to coverage for rehabilitative services and devices shall be applied to coverage for habilitative services and devices.
 - (4) Habilitative services and devices in addition to those covered by the base-benchmark plan shall be covered consistent with the definition in section 10112.27 of the Insurance Code.
- (h) An individual or small group health insurance policy shall not include a benefit design, nor shall a health insurer implement a benefit design, that discriminates against an individual based on any of the following factors:
 - (1) Age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.
 - (2) Race, color, religion, national origin, ancestry, sex, gender, gender identity, gender expression, sexual orientation, or genetic characteristics.

NOTE: Authority cited: sections 10112.27, 10112.3, 12921, and 12926, Insurance Code.
 Reference: sections 10112.27, 10112.3, 10140, Insurance Code.

Adopt: Section 2594.3. Essential Health Benefits.

- (a) Essential health benefits are defined to include all of the following:
 - (1) Health benefits within the ten categories of essential health benefits enumerated in subdivision (a)(1) of section 10112.27. Provided that a stand-alone pediatric dental plan is certified to be offered on the Exchange pursuant to section 1302(b)(4)(F) of PPACA (42 U.S.C. § 18022(b)(4)(F)), a health insurer participating in the Exchange may, but is not required to, omit coverage of the pediatric oral essential health benefit in a health insurance policy sold on the Exchange. A health insurance policy sold on the Exchange shall not omit coverage of the pediatric oral essential health benefit when sold outside of the Exchange pursuant to subdivision (c)(1) of Insurance Code section 10112.3 or otherwise.
 - (2) Medically necessary basic health care services, as defined in subdivision (b) of section 1345 of the Health and Safety Code and section 1300.67 of Title 28 of the California Code of Regulations.
 - (3) The health benefits mandated to be covered by the base-benchmark plan pursuant to all of the following:

- (A) The sections of the Health and Safety Code enumerated in subdivisions (a)(2)(A)(ii) and (a)(2)(A)(iv) of section 10112.27 of the Insurance Code.
 - (B) Subdivision (a) of section 1300.67.24 of Title 28 of the California Code of Regulations.
 - (C) Section 1300.68.2 of Title 28 of the California Code of Regulations.
- (4) Durable medical equipment for home use and prosthetic and orthotic devices covered by the base-benchmark plan, including, but not limited to, all of the following:
- (A) Diabetic Shoes and Inserts: off-the-shelf depth-inlay shoes; custom-molded shoes; custom-molded multiple density inserts; fitting, modification, and follow-up care for podiatric devices; repair or replacement of podiatric devices.
 - (B) Glucose Monitors, Infusion Pumps, and Related Supplies: external single or multiple channel electric or battery-operated ambulatory infusion pumps; home blood glucose monitors; blood glucose test or reagent strips for home blood glucose monitors; interstitial glucose monitors; programmable and non-programmable implantable infusion pumps; infusion pump used for uninterrupted parenteral administration of medication; infusion sets for external insulin pumps; infusion supplies for external drug infusion pumps; lancets; calibrator solution/chips; single or multi-channel stationary parenteral infusion pumps; replacement batteries for home blood glucose monitors and infusion pumps; spring-powered device for lancet; syringe with needle for insulin pump.
 - (C) Respiratory Drug Delivery Devices: large and small volume nebulizers; disposable and non-disposable administration sets; aerosol compressors; aerosol mask; disposable and non-disposable corrugated tubing for nebulizers; disposable and non-disposable filters for aerosol compressors; peak expiratory flow rate meter; distilled water for nebulizer; water collection device for nebulizer.
 - (D) Tracheostomy Equipment: artificial larynx; replacement battery for artificial larynx; tracheo-esophageal voice prosthesis; tracheostomy supplies, including: adhesive disc, filter, inner cannula, tube, tube plug/stop, tube collar/holder, cleaning brush, mask, speaking valve, gauze, sterile water, waterproof tape, and tracheostomy care kits.
 - (E) Canes and Crutches: adjustable and fixed canes, including standard curved handle and quad canes; adjustable and fixed crutches, including underarm and forearm crutches; replacement supplies for canes and crutches, including handgrips, tips, and underarm pads.
 - (F) Dry pressure pad for a mattress.
 - (G) Cervical traction equipment (over door).

- (H) Osteogenesis Stimulation Devices: non-invasive electrical osteogenesis stimulators, for spinal and non-spinal applications; non-invasive low density ultrasound osteogenesis stimulator.
 - (I) Enteral and Parenteral Nutrition: enteral formula and additives, adult and pediatric, including for inherited diseases of metabolism; enteral feeding supply kits; enteral nutrition infusion pump; enteral tubing; gastrostomy/jejunostomy tube and tubing adaptor; nasogastric tubing; parenteral nutrition infusion pump; parenteral nutrition solutions; stomach tube; supplies for self-administered injections.
 - (J) Hospital grade breast pump and double breast pump kit.
 - (K) IV pole.
 - (L) Phototherapy (bilirubin) light with photometer.
 - (M) Compression burn garment; lymphedema gradient compression stocking; light compression bandage; manual compression garment; moderate compression bandage.
 - (N) Non-segmental home model pneumatic compressor for the lower extremities.
 - (O) Prosthetic Devices Incident to Mastectomy: prosthetic devices incident to a mastectomy, including custom-made prostheses when medically necessary; adhesive skin support attachment for use with external breast prosthesis; and brassieres for breast prostheses.
 - (P) Prosthetic devices to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect.
- (5) Health benefits covered by the base-benchmark plan not otherwise required to be covered under Chapter 2.2 (commencing with section 1340) of Division 2 of the Health and Safety Code, including, but not limited to, all of the following:
- (A) Acupuncture services.
 - (B) Chemical dependency and substance use disorder services.
 - (C) Contact lenses to treat aniridia and aphakia.
 - (D) Health benefits for prenatal diagnosis of fetal genetic disorders.
 - (E) Home hemodialysis and home peritoneal dialysis equipment and medical supplies.
 - (F) Mental health services.
 - (G) Nonemergency licensed ambulance and psychiatric transport van services when the vehicle transports the insured to or from covered services and the use of other means of transportation may endanger the insured's health.
 - (H) Organ, tissue, or bone marrow transplant donation services for an actual or potential living transplant donor, including for harvesting of organs, tissue, or bone marrow and treatment of complications, when the transplant recipient is covered by the health insurance policy.
 - (I) Ostomy and urological supplies:

- (i) Ostomy supplies: adhesives; adhesive remover; ostomy belt; hernia belts; catheter; skin wash/cleaner; bedside drainage bag and bottle; urinary leg bags; gauze pads; irrigation faceplate; irrigation sleeve; irrigation bag; irrigation cone/catheter; lubricant; urinary connectors; gas filters; ostomy deodorants; drain tube attachment devices; gloves; stoma caps; colostomy plug; ostomy inserts; urinary and ostomy pouches; barriers; pouch closures; ostomy rings; ostomy face plates; skin barrier; skin sealant; waterproof and non-waterproof tape.
 - (ii) Urological supplies: adhesive catheter skin attachment; catheter insertion trays with and without catheter and bag; male and female external collecting devices; male external catheter with integral collection chamber; irrigation tubing sets; indwelling catheters; foley catheters; intermittent catheters; cleaners; skin sealants; bedside and leg drainage bags; bedside bag drainage bottle; catheter leg straps; irrigation tray; irrigation syringe; lubricating gel; sterile individual packets; tubing and connectors; catheter clamp or plug; penile clamp; urethral clamp or compression device; waterproof and non-waterproof tape; catheter anchoring device.
 - (iii) Incontinence supplies for hospice patients: disposable incontinence underpads; adult incontinence garments.
 - (J) Skilled nursing facility services.
- (6) Pediatric services, including all of the following:
 - (A) The following health benefits for pediatric oral care:
 - (i) Dental and orthodontic benefits covered by the base-benchmark plan.
 - (ii) Dental benefits covered by the Healthy Families Program plan.
 - (iii) Orthodontic benefits when medically necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.
 - (B) The following health benefits for pediatric vision care:
 - (i) Vision benefits covered by the base-benchmark plan.
 - (ii) Vision benefits covered by the Federal Employees Dental and Vision Insurance Program plan.
- (b) Essential health benefits do not include the following:
 - (1) Routine non-pediatric eye exam services for refraction to determine the need for vision correction and provide a prescription for eyeglass lenses, but not excluding examination of the eye for other purposes, including preventive screening for conditions such as hypertension, diabetes, glaucoma, or macular degeneration.
 - (2) The cost sharing provisions or network limitations of the base-benchmark plan, the Healthy Families Program plan, or the Federal Employees Dental

and Vision Insurance Program plan, except to the extent otherwise required to comply with provisions of the Insurance Code, and as otherwise applicable to all individual and small group health insurance policies.

NOTE: Authority cited: sections 10112.27, 12921, and 12926, Insurance Code.
Reference: section 10112.27, Insurance Code.

Adopt: Section 2594.4. Prescription Drug Coverage.

- (a) An individual or small group health insurance policy shall provide coverage for prescription drugs that complies with all of the following:
 - (1) The sections of the Health and Safety Code enumerated in subdivisions (a)(2)(A)(ii) and (a)(2)(A)(iv) of section 10112.27 of the Insurance Code that apply to prescription drugs.
 - (2) Section 1300.67.24 of Title 28 of the California Code of Regulations.
 - (3) Subsection (a) of section 156.122 of Title 45 of the Code of Federal Regulations.
- (b) A health insurer shall submit all of the following to the Commissioner together with a health insurance policy form pursuant to section 10290 of the Insurance Code, and annually on July 1 thereafter:
 - (1) A list reporting the number of chemically distinct prescription drugs covered in each United States Pharmacopeia category and class and an attestation to the truth and accuracy of the list.
 - (2) Any prescription drug list and/or formulary associated with the policy form.
 - (3) Consumer documents describing prescription drug benefits and limitations on coverage, including any prescription drug list and/or formulary associated with the policy form that is provided to consumers.
 - (4) An attestation of compliance with section 1300.67.24 of Title 28 of the California Code of Regulations.

NOTE: Authority cited: sections 10112.27, 12921, and 12926, Insurance Code.
Reference: sections 10112.27, 10290, Insurance Code.

Adopt: Section 2594.5. Annual Limitations on Cost Sharing and Small Group Deductibles.

- (a) An individual or small group health insurance policy shall comply with the annual limitation on cost sharing described in subsection (c)(1) of section 1302 of PPACA (42 U.S.C. § 18022(c)(1)), and as specified in subsection (a) of section 156.130 of Title 45 of the Code of Federal Regulations.
- (b) A small group health insurance policy shall comply with the annual limitation on deductibles described in subsection (c)(2) of section 1302 of PPACA (42 U.S.C. § 18022(c)(2)), and as specified in subsection (b) of section 156.130 of Title 45 of the Code of Federal Regulations.
- (c) An individual or small group health insurance policy shall comply with subsection (g) of section 156.130 of Title 45 of the Code of Federal Regulations.

NOTE: Authority cited: sections 10112.27, 12921, and 12926, Insurance Code.
Reference: section 10112.27, Insurance Code.

Adopt: Section 2594.6. Levels of Coverage for Essential Health Benefits.

- (a) An individual health insurance policy shall, consistent with subdivision (d) of section 10112.3 of the Insurance Code, provide only the following levels of coverage:
 - (1) The four levels of coverage described in subsection (d) of section 1302 of PPACA (42 U.S.C. § 18022(d)), and as specified in section 156.140 of Title 45 of the Code of Federal Regulations.
 - (2) Catastrophic coverage in accordance with subsection (e) of section 1302 of PPACA (42 U.S.C. § 18022(e)), and as specified in section 156.155 of Title 45 of the Code of Federal Regulations.
- (b) A small group health insurance policy shall provide only the four levels of coverage described in subsection (d) of section 1302 of PPACA (42 U.S.C. § 18022(d)), and as specified in section 156.140 of Title 45 of the Code of Federal Regulations.
- (c) An individual or small group health insurance policy shall prominently disclose the level of coverage it provides.

NOTE: Authority cited: sections 10112.27, 10112.3, 12921, and 12926, Insurance Code.
Reference: sections 10112.27, 10112.3, Insurance Code.

Adopt: Section 2594.7. Demonstration of Actuarial Value for Essential Health Benefits.

- (a) A health insurer shall submit all of the following to the Commissioner together with a health insurance policy form pursuant to section 10290 of the Insurance Code:
 - (1) A statement of variables specifying the cost sharing values for each level of coverage provided and, if applicable, catastrophic coverage, for all health benefits subject to cost sharing; and
 - (2) If the benefit design is compatible with the federal Actuarial Value Calculator, completed Excel tabs entitled “User Inputs for Plan Parameters” from the calculator for each level of coverage provided; or
 - (3) If the benefit design is incompatible with the federal Actuarial Value Calculator, an actuarial certification of the methodology chosen to determine actuarial value from the two options specified in subsection (b) of section 156.135 of Title 45 of the Code of Federal Regulations.
- (b) The statement of variables shall include all of the following:
 - (1) Specified values for all health benefits subject to cost sharing for each level of coverage provided and, if applicable, catastrophic coverage.
 - (2) An index to the locations of the variable brackets in the policy form.
- (c) If the benefit design is incompatible with the federal Actuarial Value Calculator, meaning that the calculator does not take into account or accommodate all material aspects of the cost sharing structure, a health insurer shall submit an actuarial certification containing all of the following:

- (1) A statement of the qualifications of the actuary who prepared the certification. The certifying actuary shall be a member of the American Academy of Actuaries and shall meet the qualification standards stated in *Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States* (American Academy of Actuaries, Jan. 1, 2008 (incorporated by reference)).
- (2) A description of the methodology chosen to determine actuarial value from the two options specified in subsection (b) of section 156.135 of Title 45 of the Code of Federal Regulations. The description shall be sufficiently clear and detailed that another qualified health actuary can make an objective appraisal of the reasonableness of the data, assumptions, factors, models, methods, formulas, and calculations used to determine the actuarial value for each level of coverage provided. The description shall include all of the following:
 - (A) The data, assumptions, factors, models, methods, formulas, and calculations used to determine the actuarial value for each level of coverage provided.
 - (B) The actuarial value for each level of coverage provided.
 - (C) A discussion of the standard population used to determine the actuarial value for each level of coverage provided.
 - (D) Confirmation that only in-network cost sharing, including multi-tier networks, was included in the calculation of actuarial value.
- (3) A statement of opinion attesting to the following, as applicable:
 - (A) For the method described in subsection (b)(2) of section 156.135 of Title 45 of the Code of Federal Regulations, that the plan design was fit appropriately, in accordance with generally accepted actuarial principles and methodologies, into the parameters of the federal Actuarial Value Calculator.
 - (B) For the method described in subsection (b)(3) of section 156.135 of Title 45 of the Code of Federal Regulations, that appropriate adjustments were made, in accordance with generally accepted actuarial principles and methodologies, to the actuarial value identified by the federal Actuarial Value Calculator.
- (d) When the actuarial values associated with a previously submitted health insurance policy form are no longer within the allowable range for the levels of coverage specified in section 156.140 of Title 45 of the Code of Federal Regulations, a health insurer shall submit either of the following to the Commissioner:
 - (1) A new or revised policy form together with the documents required under subdivision (a) of this section demonstrating compliance with the levels of coverage specified in section 156.140 of Title 45 of the Code of Federal Regulations; or
 - (2) If a change to the text of the policy form is unnecessary, only the documents required under subdivision (a) of this section demonstrating compliance with the levels of coverage specified in section 156.140 of Title 45 of the Code of Federal Regulations.

- (e) If a small group health insurance policy is offered in conjunction with a health savings account or an integrated health reimbursement arrangement to which an employer makes contributions and that may only be used for cost sharing pursuant to subsection (c) of section 156.135 of Title 45 of the Code of Federal Regulations, and the employer contributions are taken into account when calculating the actuarial value of the policy, the policy form and statement of variables required by subdivision (a)(1) of this section shall include either of the following:
- (1) A value for the annual employer contribution to health savings accounts or amounts newly made available under health reimbursement arrangements for the year; or
 - (2) A range of values for the annual employer contribution to health savings accounts or amounts newly made available under health reimbursement arrangements for the year, provided that the actuarial value remains within the allowable range for each level of coverage provided. A health insurer shall demonstrate that the actuarial value is within the allowable range by including in the documents required under subdivision (a)(2) or (a)(3) of this section verification of actuarial value for both the minimum and maximum annual employer contribution for each level of coverage provided.
- (f) A stand-alone pediatric dental plan shall comply with section 156.150 of Title 45 of the Code of Federal Regulations and shall submit an actuarial certification to the Commissioner together with the policy form pursuant to section 10290 of the Insurance Code. The certification shall contain all of the following:
- (1) A statement of the qualifications of the actuary who prepared the certification. The certifying actuary shall be a member of the American Academy of Actuaries and shall meet the qualification standards stated in *Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States* (American Academy of Actuaries, Jan. 1, 2008 (incorporated by reference)).
 - (2) A description of the methodology used to determine the actuarial value of the pediatric oral essential health benefit for the low and/or high levels of coverage specified in section 156.150 of Title 45 of the Code of Federal Regulations. The description shall be sufficiently clear and detailed that another qualified health actuary can make an objective appraisal of the reasonableness of the data, assumptions, factors, models, methods, formulas, and calculations used to determine the actuarial value. The description shall include all of the following:
 - (A) The data, assumptions, factors, models, methods, formulas, and calculations used to determine the actuarial value of the pediatric oral essential health benefit for the levels of coverage provided.
 - (B) The actuarial value of the pediatric oral essential health benefit for the levels of coverage provided.
 - (3) A statement of opinion attesting that the actuarial values reported are based on generally accepted actuarial principles and methodologies.

NOTE: Authority cited: sections 10112.27, 10112.3, 12921, and 12926, Insurance Code.
Reference: sections 10112.27, 10112.3, 10290, Insurance Code.